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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **TRACY ANELL AINSWORTH** 34 Bramblewood Court Cartersville, GA 30120 Registered Nurse License No. 646900 Respondent.	Case No. 2010-175 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about October 25, 2004, the Board issued Registered Nurse License Number 646900 to Tracy Anell Ainsworth ("Respondent"). Respondent's registered nurse license expired on January 31, 2006.

STATUTORY PROVISIONS

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive

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license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

5. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
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> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions . . .

6. Code section 2762 states, in pertinent part:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
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> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
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> . . . .
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> (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

7. Code section 4060 states, in pertinent part:

> No person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7, or furnished pursuant to a drug order issued by a certified nurse-midwife pursuant to Section 2746.51, a nurse practitioner pursuant to Section 2836.1, a physician assistant pursuant to Section 3502.1, a naturopathic doctor pursuant to Section 3640.5, or a pharmacist pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052 . . .

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8. Health and Safety Code section 11173, subdivision (a), states, in pertinent part, that "[n]o person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge . . ."

9. California Code of Regulations, title 16, section ("Regulation") 1442 states:

> As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

COST RECOVERY

10. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CONTROLLED SUBSTANCES AT ISSUE

11. "Morphine" is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(M).

12. "Dilaudid" , a brand of hydromorphone, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(K).

13. "Demerol", a brand of meperidine hydrochloride, a derivative of pethidine, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (c)(17).

FIRST CAUSE FOR DISCIPLINE

(Diversion and Possession of Controlled Substances)

14. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762,

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subdivision (a), in that in or about November 2004, while on duty as a registered nurse at Mercy General Hospital, Sacramento, California, Respondent did the following:

Diversion of Controlled Substances:

a. Respondent obtained the controlled substances morphine, Dilaudid, and Demerol by fraud, deceit, misrepresentation, or subterfuge, in violation of Health and Safety Code section 11173, subdivision (a), as follows: During the time period indicated above, Respondent removed various quantities of morphine, Dilaudid, and Demerol from the hospital's SureMed system (a computerized medication dispensing system; hereinafter "SureMed") for certain patients when there were no physicians' orders authorizing the medications for the patients, or the quantities of the medications removed from the SureMed were in excess of the doses ordered by the patients' physicians. Further, in some instances, Respondent removed controlled substances from the SureMed after the patients had already been discharged from the hospital or when the patients were not assigned to Respondent. In addition, Respondent failed to chart the administration of the controlled substances on the patients' Medication Administration Records (MAR), failed to document the wastage of the controlled substances in the SureMed, or falsified or made grossly incorrect, grossly inconsistent, or unintelligible entries on the MAR's to conceal her diversion of the controlled substances, as set forth in paragraph 15 below.

Possession of Controlled Substances:

b. During the time period indicated above, Respondent possessed unknown quantities of the controlled substances morphine, Dilaudid, and Demerol without valid prescriptions from a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor, in violation of Code section 4060.

SECOND CAUSE FOR DISCIPLINE

(False Entries in Hospital/Patient Records)

15. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (e), in that in or about November 2004, while on duty as a registered nurse at Mercy General Hospital, Sacramento, California, Respondent falsified, or made grossly incorrect,

grossly inconsistent, or unintelligible entries in hospital, patient, or other records pertaining to the controlled substances morphine, Dilaudid, and Demerol, as follows:

Patient A.G.:

a. On November 1, 2004, at 1239 hours, Respondent removed morphine 10 mg from the SureMed for patient A.G., but failed to chart the administration of the morphine on the patient's MAR, document the wastage of the morphine in the SureMed, and otherwise account for the disposition of the morphine 10 mg.

b. On November 1, 2004, at 1429 hours, Respondent removed morphine 10 mg from the SureMed for patient A.G., but failed to chart the administration of the morphine on the patient's MAR, document the wastage of the morphine in the SureMed, and otherwise account for the disposition of the morphine 10 mg.

c. On November 1, 2004, at 1544 hours, Respondent removed morphine 10 mg from the SureMed for patient A.G., but failed to chart the administration of the morphine on the patient's MAR, document the wastage of the morphine in the SureMed, and otherwise account for the disposition of the morphine 10 mg.

d. On November 1, 2004, at 1723 hours, Respondent removed morphine 10 mg from the SureMed for patient A.G., documented in the SureMed at 1724 hours that she wasted morphine 4 mg as witnessed by another nurse, but failed to chart the administration of the remaining 6 mg of morphine on the patient's MAR and otherwise account for the disposition of the morphine 6 mg.

Patient W.B.:

e. On November 1, 2004, at 1121 hours, Respondent removed morphine 10 mg from the SureMed for patient W.B. when, in fact, the physician's order called for the administration of only 2 to 4 mg morphine for the patient. Further, Respondent documented in the SureMed at 1126 hours that she wasted morphine 8 mg as witnessed by another nurse, but failed to chart the administration of the remaining 2 mg of morphine on the patient's MAR and otherwise account for the disposition of the morphine 2 mg.

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Patient L.H.:

f. On November 1, 2004, at 0820 hours, Respondent removed morphine 10 mg from the SureMed for patient L.H. when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the morphine on the patient's MAR, document the wastage of the morphine in the SureMed, and otherwise account for the disposition of the morphine 10 mg.

g. On November 1, 2004, at 0959 hours, Respondent removed Dilaudid 4 mg from the SureMed for patient L.H. when, in fact, the physician's order called for the administration of only 2 to 3 mg Dilaudid for the patient. Further, Respondent charted on the patient's MAR that she administered Dilaudid 3 mg to the patient at 1000 hours, but failed to document the wastage of the remaining 1 mg Dilaudid in the SureMed and otherwise account for the disposition of the Dilaudid 1 mg.

h. On November 1, 2004, at 1357 hours, Respondent removed Dilaudid 4 mg from the SureMed for patient L.H. when, in fact, the physician's order called for the administration of only 2 to 3 mg Dilaudid for the patient. Further, Respondent charted on the patient's MAR that she administered Dilaudid 3 mg to the patient at 1400 hours, but failed to document the wastage of the remaining 1 mg Dilaudid in the SureMed and otherwise account for the disposition of the Dilaudid 1 mg.

i. On November 1, 2004, at 1543 hours, Respondent removed Dilaudid 4 mg from the SureMed for patient L.H. when, in fact, the physician's order called for the administration of only 2 to 3 mg Dilaudid for the patient. Further, Respondent charted on the patient's MAR that she administered Dilaudid 3 mg to the patient at 1600 hours, but failed to document the wastage of the remaining 1 mg Dilaudid in the SureMed and otherwise account for the disposition of the Dilaudid 1 mg.

j. On November 1, 2004, at 1806 hours, Respondent removed Dilaudid 4 mg from the SureMed for patient L.H. when, in fact, the physician's order called for the administration of only 2 to 3 mg Dilaudid for the patient. Further, Respondent charted on the patient's MAR that she administered Dilaudid 3 mg to the patient at 1800 hours, but failed to document the wastage of

the remaining 1 mg Dilaudid in the SureMed and otherwise account for the disposition of the Dilaudid 1 mg.

Patient T.E.:

k. On November 1, 2004, at 0833 hours, Respondent removed morphine 2 mg from the SureMed for patient T.E., but failed to chart the administration of the morphine on the patient's MAR, document the wastage of the morphine in the SureMed, and otherwise account for the disposition of the morphine 2 mg.

l. On November 1, 2004, at 0955 hours, Respondent removed morphine 4 mg from the SureMed for patient T.E. when, in fact, the patient had been discharged from the hospital at 0850 hours. Further, Respondent failed to chart the administration of the morphine on the patient's MAR, document the wastage of the morphine in the SureMed, and otherwise account for the disposition of the morphine 4 mg.

Patient P.L.:

m. On November 15, 2004, at 1231 hours, Respondent removed Dilaudid 2 mg from the SureMed for patient P.L. when, in fact, the physician's order called for the administration of only 1 mg Dilaudid for the patient, charted on the patient's MAR that she administered Dilaudid 1 mg to the patient at 1145 hours, and failed to document the wastage of the remaining 1 mg Dilaudid in the SureMed and otherwise account for the disposition of the Dilaudid 1 mg.

n. On November 15, 2004, at 1232 hours, Respondent removed morphine 10 mg from the SureMed for patient P.L. when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the morphine on the patient's MAR, document the wastage of the morphine in the SureMed, and otherwise account for the disposition of the morphine 10 mg.

o. On November 15, 2004, at 1307 hours, Respondent removed Demerol 100 mg from the SureMed for patient P.L. when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Demerol on the patient's MAR, document the wastage of the Demerol in the SureMed, and otherwise account for the disposition of the Demerol 100 mg.

p. On November 15, 2004, at 1627 hours, Respondent removed Dilaudid 1 mg from the SureMed for patient P.L. when, in fact, the patient had been discharged from the hospital at 1620 hours. Further, Respondent failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the SureMed, and otherwise account for the disposition of the Dilaudid 1 mg.

Patient E.B.:

q. On November 15, 2004, at 1750 hours, Respondent removed Demerol 100 mg from the SureMed for patient E.B. when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Demerol on the patient's MAR, document the wastage of the Demerol in the SureMed, and otherwise account for the disposition of the Demerol 100 mg.

Patient S.M.:

r. On November 15, 2004, at 1837 hours, Respondent removed Demerol 100 mg from the SureMed for patient S.M. when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Demerol on the patient's MAR, document the wastage of the Demerol in the SureMed, and otherwise account for the disposition of the Demerol 100 mg. In addition, Respondent was not assigned to the patient.

Patient J.K.:

s. On November 22, 2004, at 1519 hours, Respondent removed a total of 20 mg of morphine for patient J.K. when, in fact, the physician's order called for the administration of only 2 mg morphine for the patient, charted on the patient's MAR that she administered morphine 2 mg to the patient at 1530 hours, and failed to document the wastage of the remaining 18 mg morphine in the SureMed and otherwise account for the disposition of the morphine 18 mg.

Patient A.C.:

t. On November 22, 2004, at 2114 hours, Respondent removed Dilaudid 2 mg from the SureMed for patient A.C. when, in fact, the physician's order called for the administration of only 1 mg Dilaudid for the patient. Further, Respondent failed to chart the administration of the

Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the SureMed, and otherwise account for the disposition of the Dilaudid 2 mg.

Patient R.G.:

u. On November 22, 2004, at 2025 hours, Respondent removed Demerol 100 mg from the SureMed for patient R.G. when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Demerol on the patient's MAR, document the wastage of the Demerol in the SureMed, and otherwise account for the disposition of the Demerol 100 mg.

v. On November 22, 2004, at 2044 hours, Respondent removed morphine 10 mg from the SureMed for patient R.G. when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the morphine on the patient's MAR, document the wastage of the morphine in the SureMed, and otherwise account for the disposition of the morphine 10 mg.

Patient L.A.:

w. On November 22, 2004, at 1746 hours, Respondent removed morphine 10 mg from the SureMed for patient L.A. when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the morphine on the patient's MAR, document the wastage of the morphine in the SureMed, and otherwise account for the disposition of the morphine 10 mg.

Patient C.F.:

x. On November 22, 2004, at 1942 hours, Respondent removed Demerol 100 mg from the SureMed for patient C.F. when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Demerol on the patient's MAR, document the wastage of the Demerol in the SureMed, and otherwise account for the disposition of the Demerol 100 mg.

y. On November 22, 2004, at 2149 hours, Respondent removed Dilaudid 2 mg from the the SureMed for patient C.F. when, in fact, the physician's order was not issued for the medication until 2155 hours. Further, Respondent charted on the patient's MAR that she

administered Dilaudid 1 mg to the patient at 2200 hours, but failed to document the wastage of the remaining 1 mg Dilaudid in the SureMed and otherwise account for the disposition of the 1 mg Dilaudid.

z. On November 22, 2004, at 2228 hours, Respondent removed Dilaudid 2 mg from the the SureMed for patient C.F., but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the SureMed, and otherwise account for the disposition of the Dilaudid 2 mg.

aa. On November 22, 2004, at 2229 hours, Respondent removed a total of 20 mg of morphine from the SureMed for patient C.F. when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the morphine on the patient's MAR, document the wastage of the morphine in the SureMed, and otherwise account for the disposition of the morphine 20 mg.

Patient T.K.:

bb. On November 23, 2004, at 1457 hours, Respondent removed a total of 200 mg of Demerol from the SureMed for patient T.K. when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Demerol on the patient's MAR, document the wastage of the Demerol in the SureMed, and otherwise account for the disposition of the Demerol 200 mg. In addition, Respondent was not assigned to the patient.

Patient E.H.:

cc. On November 23, 2004, at 1519 hours, Respondent removed a total of 200 mg of Demerol from the SureMed for patient E.H. when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Demerol on the patient's MAR, document the wastage of the Demerol in the SureMed, and otherwise account for the disposition of the Demerol 200 mg.

dd. On November 23, 2004, at 1535 hours, Respondent removed Dilaudid 4 mg from the SureMed for patient E.H. when, in fact, the physician's order called for the administration of only 1 mg Dilaudid for the patient. Further, Respondent charted on the patient's MAR that she

administered 1 mg Dilaudid to the patient at 1605 hours, but failed to document the wastage of the remaining 3 mg of Dilaudid in the SureMed and otherwise account for the disposition of the 3 mg Dilaudid.

ee. On November 23, 2004, at 1634 hours, Respondent removed morphine 10 mg from the SureMed for patient E.H. when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the morphine on the patient's MAR, document the wastage of the morphine in the SureMed, and otherwise account for the disposition of the morphine 10 mg.

Patient H.C.:

ff. On November 23, 2004, at 1827 hours, Respondent removed Dilaudid 2 mg from the SureMed for patient H.C. when, in fact, the physician's order called for the administration of only 1 mg Dilaudid for the patient. Further, Respondent charted on the patient's MAR that she administered 1 mg Dilaudid to the patient at 1845 hours, but failed to document the wastage of the remaining 1 mg of Dilaudid in the SureMed and otherwise account for the disposition of the 1 mg Dilaudid.

gg. On November 23, 2004, at 1842 hours, Respondent removed a total of 20 mg of morphine from the SureMed for patient H.C. when, in fact, there was no physician's order authorizing the medication for the patient. Further, between 1845 and 1847 hours, Respondent documented in the SureMed that she wasted a total of 30 mg of morphine as witnessed by nurses C. V. and G. H.

Patient C.R.

hh. On November 23, 2004, at 1726 hours, Respondent removed morphine 10 mg from the SureMed for patient C.R. when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the morphine on the patient's MAR, document the wastage of the morphine in the SureMed, and otherwise account for the disposition of the morphine 10 mg.

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THIRD CAUSE FOR DISCIPLINE

(Gross Negligence)

16. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that in or about November 2004, while on duty as a registered nurse at Mercy General Hospital, Sacramento, California, Respondent was guilty of gross negligence within the meaning of Regulation 1442, as set forth in paragraphs 14 and 15 above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 646900, issued to Tracy Anell Ainsworth;

2. Ordering Tracy Anell Ainsworth to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 9/24/09

Louise R. Bailey

LOUISE R. BAILEY, M.Ed., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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